

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042134

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
Length of stay in 1b 10yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital #1 D.O.A.		d. STREET ADDRESS (If outside, give location) 824 Lafayette	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle TOMICH Last		4. DATE OF DEATH Month October Day 5 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (last birthday) 55
11a. BIRTHPLACE (City and state or country) Madison, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Ignatz Ciesinski		13b. MOTHER'S MAIDEN NAME Lena Kaufman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 331 X	
17. INFORMANT Joseph Sobolewski		Address 805 Greenwood St. Madison, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Essential hypertension DUE TO (c) 331 X		INTERVAL BETWEEN ONSET AND DEATH 7hrs years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5-15-63 to 10-5-63 and last saw her him alive on 10-5-63 Death occurred at 6:15PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wilfred B. Cleveland M.D.		22b. ADDRESS 1510 S. 12th St. St. Louis	
22c. DATE SIGNED 10-8-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-8-63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) Madison Co., Illinois			
24. FUNERAL DIRECTOR ADDRESS John L. Sedlack Madison, Illinois		25. DATE RECD. BY LOCAL REG. OCT 8 1963	
26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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